105 MEDICAID BILLING AND PAYMENT

Medicaid payment must be made directly to the contracted person, entity, or institution providing the care or service unless conditions under #2 below are met. Federal regulations prohibit factoring or reassignment of payment.

a. A provider may use a billing agent to complete Medicaid billing only if the compensation for this service is:

1. related to the actual cost of processing the billing;

2. not related on a percentage or other basis to the amount that is billed or collected; and

3. not dependent on the collection of the payment.

b. Medicaid payment for an individual practitioner may be made to:

1. the employer of a practitioner if the practitioner is required, as a condition of employment, to turn over his fees to his employer;

2. the group if the practitioner and the group have a contract in place under which the group submits the claims;

3. the facility in which the services is provided, if the practitioner has a contract under which the facility submits the claims; or

4. a foundation, plan or similar organization operating an organized health care delivery system if the practitioner has a contract under which the organization submits the claims. An "organized health care delivery system" may be a public or private Health Maintenance Organization (HMO).

105.1 MEDICAID PAYMENTS TO PROVIDERS

A. As specified in federal regulations and the terms of all provider agreements, Medicaid payment is payment in full. Providers may not attempt to collect additional money directly from recipients. This includes, but is not limited to, situations where the provider's claim is denied by Medicaid for failure to bill timely, accurately, or when Medicaid payment equates to zero because a third party's payment exceeds Medicaid's allowable amount.

B. Medicaid utilizes the Centers for Medicare and Medicaid Services (CMS) developed National Correct Coding Initiative (NCCI) to control improper coding that leads to inappropriate payments. The National Correct Coding Initiative (NCCI) edits are defined

as edits applied to services performed by the same provider for the same beneficiary on the same date of service. They consist of two types of edits:

1. NCCI edits, or procedure-to-procedure edits that define pairs of Healthcare Common Procedure Coding System (HCPCS)/ Current Procedural Terminology (CPT) codes that should not be reported together for a variety of reasons; and

2. Medically Unlikely Edits (MUEs) or units-of-service edits that define for each HCPCS/CPT code the number of units of service beyond which the reported number of units of service is unlikely to be correct.

C. Nevada Medicaid utilizes a clinical claims editor program to enhance the adjudication process for Nevada Medicaid/Check Up claims for professional services. The claims editor program employs a nationally recognized standardized method of processing claims for professional services using clinical logic based on the most current CPT, HCPCS, International Classification of Diseases (ICD)~~-9-C~~, American Medical Association (AMA), CMS and specialty societal guidelines. The claim editor results in consistent claims adjudication for all providers of professional services and increased claims payment turnaround time.

D. If an individual is pending Medicaid, it is requested the provider await an eligibility decision before billing for the service. If the provider decides not to wait for the decision, he or she may request payment from the recipient while the decision is pending. Once the recipient is found eligible for Medicaid, and the date of service for which payment was collected is covered, the provider must return the entire amount collected to the recipient before billing Medicaid. The payment subsequently received from Medicaid is payment in full and no additional payment may be requested from the recipient, and no part of the payment made by the recipient may be retained by the provider.

E. Providers are to bill their usual and customary fees unless otherwise specified in Medicaid policy. For exceptions, refer to individual chapters. Billings are submitted according to established Medicaid policies.

F. Appropriate billings must include the current year procedure codes and ICD~~-9-CM~~ diagnostic codes or the Health Insurance Portability and Accountability Act (HIPAA) of 1996 compliant codes. Complete billing information may be obtained by contacting the Medicaid Field Representative at Medicaid's fiscal agent. Refer to Section 108 of this chapter for additional contact information.

G. Claims for payment are to be sent to Nevada Medicaid's fiscal agent on an appropriate billing form. Claims may be submitted either through electronic media or by paper. Refer to Section 108 of this chapter for addresses and other information.

H. It is the provider's responsibility to submit clean, accurate and complete claims to assure accurate payment within Medicaid time frames. All claims must be of sufficient quality to allow electronic imaging and OCR therefore, corrections are not allowed. All paper claims must be submitted on the original applicable CMS-1500 or UB04 claim forms. Facsimiles, photocopies, or laser-printed claim forms may not be scanned and are unacceptable.

Those claims not meeting this criterion will be returned from the fiscal agent to the provider. The claims will not be stamped as received and there will be no record of receipt.

I. Nevada Medicaid will neither accept nor reimburse professional billings for services rendered by other than the provider under whose name and provider number the claims is submitted (e.g., a claim for an office visit submitted by a physician when a psychologist or other personnel actually provided the service). Individuals who do not meet Medicaid criteria for provider numbers must not have their services billed as through a physician/dentist to the Medicaid program for payment.

J. Medical residents do not meet Medicaid criteria for provider status. No service provided by a medical resident is to be submitted by another licensed physician/dentist to the Medicaid program for payment except by the teaching physician under the policy guidance in Medicaid Services Manual (MSM) Chapter 600.

K. Payments are made only to providers. (Recipients who provide transportation for themselves and/or other recipients may be reimbursed as providers under certain circumstances.) A provider cannot request payment from Medicaid recipients assuming Medicaid will reimburse the recipient. Optional reimbursement to a patient is a characteristic of the Medicare Program, not the Medicaid program.

L. Providers are required to keep any records necessary to disclose the extent of services the provider furnishes to recipients and to provide these records, upon request, to the Medicaid agency, the Secretary of Health and Human Services (HHS), or the state Medical Fraud Control Unit (MFCU).

M. When payment appears to be unduly delayed, a duplicate billing labeled "duplicate" or "tracer" may be submitted. Failure to indicate "duplicate" or "tracer" may be interpreted as a fraudulent practice intended to secure improper double payment.

Group practices should make certain that rebilling shows the same service codes, the same physician's name and the same Medicaid provider number. If it should be necessary to alter the billing to show different codes or descriptors, a copy of the previous claim should be attached to the revised billing.